

TO THE EDITOR, *British Journal of Venereal Diseases*

Role of the VDRL test in the detection of syphilis

Sir,
I sincerely apologise for any misquotation I may have made (*Br J Vener Dis* 1983; 59:8-10). I should have been more careful where I placed my reference indicators. The Edinburgh work is quoted in demonstration of the specificities and sensitivities of the VDRL and TPHA tests. I quoted Fiumara's larger series to show specific tests becoming negative with treatment, though his work refers to the FTA-ABS test rather than the TPHA. I stand corrected, though it makes no difference to the conclusions of the paper.

I do not agree with Southampton Public Health Laboratory's logic in withdrawing the VDRL test from initial screening of sera from genitourinary and antenatal clinics yet including it for those from all other departments. In specialities other than genitourinary medicine, serology is requested to exclude syphilis beyond the primary stage, hence the VDRL test could safely be withdrawn from initial testing except where primary disease is suspected clinically. The question remains: "should the VDRL test be routinely performed at genitourinary medicine clinics or only if specifically requested?" Venereologists understand the value of each test in diagnosis. If suspicion of primary disease is high on epidemiological grounds, for instance if the patient is a homosexual, initial use of both tests is justifiable, otherwise it is not.

The confusion sometimes caused by biological false positive reactions adds weight to the argument for withdrawal of the VDRL test from routine initial screening for syphilis. The principle of explanatory notes for tests is a bad one.

Yours faithfully,

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TO THE EDITOR, *British Journal of Venereal Diseases*

Serotypes of antibodies against chlamydiae

Sir,
The prevalence of serum antibodies directed against *Chlamydia trachomatis* has been

studied in several population groups. The reported values vary widely, from 3% in women blood donors in London¹ to 90% in women attending an STD clinic in California.² We have investigated the prevalence and serotypes of antichlamydial antibodies in women attending the department of genitourinary medicine in Edinburgh. All female patients are screened for cervical infection with *C trachomatis*;³ the isolation rate is similar to that reported from other departments of genitourinary medicine.⁴

Sera from 479 consecutive women patients were examined for the presence of antichlamydial antibody, using the modified micro immunofluorescence test described by Trehanne and his colleagues.⁵ In 110 of the women in whom antibodies were detected there was sufficient serum for the individual serotype to be identified.

Antichlamydial IgG at a titre of $\geq 1/16$ directed against *C trachomatis* (serotypes D-K) was detected in the serum of 134 (28%) women. It was detected in 49 of 97 (50%) women from whom chlamydia was isolated and in 85 of 382 (22%) women from whom chlamydia was not isolated. Prevalence of antibody varied with age and was highest in the 20-24 year old age group. Antichlamydial IgM was detected in only one from whom chlamydia was not isolated. This antibody prevalence is lower than reported elsewhere.⁴ IgM is a labile molecule, and may have deteriorated in transit between Edinburgh and London, but this fate should not have befallen IgG.

Few antibodies to other chlamydial serotypes were detected. IgG directed against TRIC/IR/10L-207/OT, an atypical chlamydial isolate was detected in 7% of women.¹ Antibodies to this organism have been detected in London blood donors but the nature of the infection it causes remains obscure. One woman was found to have IgG directed against *C psittaci* at a titre of 1/64.

In the 110 women in whom identification of the individual serotype was possible, almost half the antibodies detected were

directed against *C trachomatis* serotype D (table). There was no association between serotype and age, diagnosis, or clinical appearance of the cervix.

Although the association between antichlamydial serum IgG and cervical infection with *C trachomatis* was statistically significant, a single estimate of serum IgG was of little value in diagnosing current infection in this sexually active population. Further studies on the distribution of individual serotypes may provide more information on the epidemiology and pathology of infection with *C trachomatis*.

Yours faithfully,

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TABLE Antibodies to the different serotypes of *C trachomatis* in 110 women

Serotypes	No (%) of women with antibodies
D	52 (47)
D/E	12 (11)
E	9 (8)
F	8 (7)
G	0 (0)
H	4 (4)
I	5 (5)
J	5 (5)
K	15 (14)